

**PSYCHO-SOCIAL INTAKE
(Adult Form)**

Rev 07/03/08

THERAPIST _____ DATE _____

Client Name: _____ Case # _____

Gender _____ Date of Birth _____ Age _____

Race/Ethnic _____ County of Residence _____

Social Security Number _____ Phone # _____

Permanent Address _____

Emergency Contact _____ Phone # _____ Relationship _____

Case Manager (Name/Agency) _____

Legal Status/Guardian _____

Referral Source _____

Stated Problem _____

FAMILY & SOCIAL INFORMATION

Marital Status _____ Length of time _____

Number of Marriages _____

Number of Children _____

Marital Relationship _____

Current Living Condition/Household Composition _____

Family of Origin _____

Describe household composition, quality of relationships, and custody/parenting issues on back of page

Siblings _____

Support System _____

Friends _____

Community Interests/Involvement _____

Religious/Spiritual Involvement _____

Ethnicity Impact _____

Legal System Involvement (Present/Past/Juvenile) _____

Interests/Hobbies _____

EDUCATIONAL & OCCUPATIONAL HISTORY

Highest Level of Education _____ Location _____

Special Classes/Retentions/Training/GPA _____

Problems While in School _____

Extracurricular _____

Current Occupation/Means of Support _____

Employment History _____

Military/Discharge Type _____

Other Sources of Income _____

Gross Weekly Income _____

VICTIMIZATION HISTORY
(note if Child or Adult)

Abuse: Physical _____
 Sexual _____
 Mental _____
 Neglect _____
 C.P.S. Involvement _____

POTENTIALLY ABUSIVE BEHAVIOR

Substance	Onset	Current	Highest	Most Recent	Tolerance/ Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
Other					
Tobacco					
Caffeine					

Sexual Activity _____
 Other (i.e. Gambling, Food) _____
 Co-Dependency Issues _____
 Substance Abuse in Family History/Significant Others: _____

MENTAL HEALTH AND AOD TREATMENT HISTORY

Counseling _____

Previous Diagnosis _____

Previous Medications/Efficacy: _____

Hospitalizations/Reasons _____

Bizarre Ideation History _____

Suicide/Homicide _____

Current AOD Treatment: _____

#AOD Treatment Episodes: Outpatient _____ Residential _____ Rehab _____

Family Mental Health History: _____

MEDICAL STATUS

Primary Physician (Name/Address) _____

Current Problems _____

Current Medications _____

Personal Medical History _____

Hospitalizations _____

History of Brain Trauma _____

Developmental Problems (language/mobility/social): _____

Sleeping Patterns _____ Onset _____ Maintenance _____

Eating Patterns _____

ADL Limitations: _____

Family Medical History _____

COGNITIVE/BEHAVIORAL FUNCTION

Height/Weight _____

Appearance _____

Grooming _____

Eye Contact/Presentation _____

Speech: Appropriate Pressured Unusual Rate: _____ Unusual Rhythm: _____ Unusual Volume: _____

Attitude: Open Responsive Guarded Defensive Malingering Varied

Oriented x3 _____

Recent Recall _____

General Fund of Knowledge: _____

Abstract Reasoning: Apple/Banana Coat/Suit Poem/Statue

Estimate of I.Q. _____

Affect: Manic Depressed Within Normal Limits Other

Mood: Varied Appropriate Depressed/Sad Euphoric Flat Constricted Other: _____

Anxiety: None Noted Situational Only Psychomotor Agitation Hypervigilance Other: _____

Thought Content:

Bizarre Ideation _____

Suicidal/Homicidal _____

Current Stressors and Coping Mechanisms: _____

Other Acute Risk Factors _____

Client strengths/assets, weaknesses/limitations, diagnostic impressions, and initial intervention goals can be found on the initial ISP/POA that has been generated as part of this diagnostic assessment.